REQUEST FOR PROPOSAL

for

Primary and Preventive Dental Health Care Services Grant

Issued by:

Michigan Department of Community Health
Oral Health Program
109 West Michigan Avenue, Fourth Floor
Lansing, Michigan 48913
Phone: (517-335-8388)
Fax: (517-335-8294)

Notification of Intent to Apply Due: January 5, 2007
Proposals Due: January 24, 2007

Copies Required: Signed Original plus 6 copies

Instructions for Completing the Primary and Preventive Dental Health Care Services Grant Application

The Abbreviated Primary and Preventive Dental Health Services Grant Application was created specifically for public and non-profit eligible organizations to reduce health barriers and health disparities in Michigan through the establishment of oral health services in dental health professional shortage areas and provide community-based dental prevention programs. Projects will be funded through two separate requests for proposals addressing increased dental access and implementation of evidence-based dental health promotion/disease prevention programs.

Grant 1: **Applicants may submit only one Abbreviated Application to increase dental access through the development of a community-based dental clinic. Requests must not exceed $67,206.**

Grant 2: **Applicants may submit only one Abbreviated Application to promote oral health through community-based dental health prevention activities. Requests must not exceed $46,007.**

Applicants should be located within a community-based clinic that offers a full range of healthcare services to populations bearing a disproportionate share of disease and disabilities.

All terms, conditions and limitations specified in the abbreviated grant application will be reviewed and scored according to relevant review criteria described in Selection Criteria on page five.

INSTRUCTIONS:
Applicants should review all included materials and selection criteria.

Applications should be typed or clearly printed. **Completed applications, including one original and six (6) copies, are due no later than 5:00 p.m., January 24, 2007 to:**

Michigan Department of Community Health
Oral Health Program
Attn: Sheila Semler, Ph.D., Oral Health Director
109 West Michigan Avenue, Fourth Floor
Lansing, Michigan 48913
Phone: (517-335-8388)
Fax: (517-335-8294)

Applicants are responsible for the timely receipt of their proposal. **PROPOSALS RECEIVED AFTER THIS DATE AND TIME WILL NOT BE CONSIDERED. E-MAIL OR FAX RESPONSES WILL NOT BE ACCEPTED.**

BACKGROUND AND PURPOSE

The Michigan Department of Community Health (MDCH) Oral Health Program is offering a grant to reduce health barriers and health disparities in Michigan through two grant proposals: Grant 1: establishment of a community-based dental clinic and a Grant 2: establishment of a community dental health coordinator. Funding for the grant is made possible through the HRSA Grants to States to Support Oral Health Workforce Activities. The grant awards of $67,206.00 (Grant 1) and $46,007 (Grant 2) are available for a 8 month period to begin February 1, 2007. The grants are designed to provide initial funds for development and implementation of projects with the expectation that once-established the projects can be sustainable through the billing of services through Medicaid and third-party payors.

ELIGIBLE APPLICANTS

Public and non-profit eligible organizations are eligible to apply. The grant recipients must be located within an existing community-based clinic that offers a full range of healthcare services to populations bearing a disproportionate share of disease and disabilities.

AVAILABILITY OF FUNDING

Grant 1 award will not exceed $67,206.
Grant 2 award will not exceed $46,007.

PROJECT PERIOD

Awards will be made for a project period of 8 months beginning February 1, 2007. Applicants will be notified of award decisions by January 29, 2007.

Any funds received by the Contractor but not spent for the specific purposes of the project must be returned to MDCH. In submitting the application, the applicant assures that funds will only be used for the intended project purpose. The Department will not assume any responsibility or liability for costs incurred by the Contractor prior the signing of an agreement. Funds will be set aside for an independent analysis, contracted at the discretion of the Department, to evaluate the relative merits of all projects funded.

CONTRACTOR RESPONSIBILITIES

The Contractor will be required to assume responsibility for all contractual activities offered in the proposal whether or not that Contractor performs them. If any part of the work is to be subcontracted, responses to the RFP must include a list of subcontractors including the firm name and address, the name of the contact person, a complete description of the work to be subcontracted, and information concerning the subcontractor's organization and abilities. The state will consider the selected Contractor to be the sole point of contact with regard to project matters, including payment of any and all charges resulting from the award.

REIMBURSEMENT MECHANISM

All contractors must sign up through the on-line vendor registration process to receive all State of Michigan payments as Electronic Funds Transfers (EFT)/Direct Deposits, as mandated by PA 533 of 2004. Vendor registration information is available through the Department of Management and Budget's web site: http://www.cpexpress.state.mi.us/

DISCLOSURE OF PROPOSAL CONTENTS

All information in an applicant's proposal is subject to disclosure under the provisions of Public Act No. 442 of 1976, known as the "Freedom of Information Act." This act also provides for the disclosure of contracts and attachments thereto.

ISSUING OFFICE

This RFP is issued by the Oral Health Program, Michigan Department of Community Health, hereafter known as the Department. The issuing office is the sole point of contact for persons/organizations who are considering preparing responses to the RFP. The award will be made to the bidder who most successfully meets the criteria of the RFP, up to the total amount of funds available within the funding level stipulated.

USE OF FUNDS

Funds available under this announcement for both Grant 1 and Grant 2 should be primarily focused on staff salaries. Funds may be used for materials, supplies and travel associated with implementing the proposed project but should not be the main focus of the proposal. Funds may not be used to supplant funds for existing projects.

1. Funds for Grant 2 (community dental health coordinator) only may be used for Equipment such as a portable dental unit.

REQUIRED CAPACITY

1. Matching funds: Matching non-Federal funds of 40% is required.
2. In-kind support: In-kind contributions of staff time and other resources are expected both from the applicant and from project partners.

The community dental health coordinator position is designed to facilitate the development of a fluoride varnish program for Early Head Start and Head Start Centers, development of a school-based/school-linked dental sealant program, and provide oral health education to pregnant women, children and other population groups.

QUESTIONS AND ANSWER PERIOD

A pre-proposal conference will not be held. Questions may be submitted up to January 19, 2007. Written answers will be sent to all parties who have submitted letters of intent. To expedite the answers, include a FAX number and/or e-mail address with the letter of intent.

SPECIFICATIONS

All proposals must address or comply with the following specifications:

- Projects must report quarterly on their effectiveness. Timely reporting and indicators of success in increasing dental sealant placement for the target population is a goal of these grants.
- Projects must focus on health status implications of the healthcare services to populations bearing a disproportionate share of disease and disabilities.
- Projects must improve access to oral health prevention measures to include fluoride varnish application and dental sealants for the target population.
- The community dental health coordinator projects must reflect the needs of and demonstrate linkages with the schools.

- Projects must support the Department's goal of increased access to care.
- Projects must be conducted within the State of Michigan.
- Projects must address all requirements of the specifications.

DIRECTIONS FOR COMPLETING THE GRANT APPLICATION:

I. Cover Sheet

A. Project Title: Enter name of project

B. Amount of Request:

C. Name of Applicant Organization: Enter in the name of the applicant organization. Enter the name and title of the person officially authorized by the applicant organization to enter into agreements, (usually chief administrative officer). Enter the mailing address, including city, county, state and ZIP code. Enter the telephone number, fax number and e-mail address.

D. Contact Person: Enter the name and title of the contact person who will be responsible for overseeing the project. Enter the mailing address, including city, county, state and ZIP code. Enter the telephone number, fax number and e-mail address.

E. Legal Status of Organization: *(check only one response)* – check the box that applies. Attach copy of requested IRS materials.

F. Federal Tax ID Number – Enter Federal Tax ID number (may also be known as Federal Employer Number) as assigned by IRS.

G. Authorizing Entity – An official authorized to bind the applicant organization to its provisions must sign the original proposal in ink. Print name and enter date of signature.

II. Proposal

A. Needs Statement -- Include the requested information.

B. Program Description/Work Plan – Attach the program description/workplan. State project goal in space provided. List objectives, activities and outcomes and the quarter in which the objectives will be accomplished in the appropriate columns.

C. Community Involvement, Collaboration, Coordination- Include the requested information. Letters of support should be attached.

D. Innovative Methods to Decrease Oral Health barriers and Oral Health Disparities— Include the requested information.

E. Experience and Qualifications—Include the requested information.

F. Project Sustainability – Include the requested information.

G. Outcome Measures and Evaluation – Include the requested information.

H. Budget Narrative – Include the requested information.

I. Budget Summary and Program Budget Cost Detail Schedule-- Using the Budget Completion instructions included in the RFP (see Attachment A), please complete both budget forms (see Attachment B1): DCH-0385 (Budget Summary) and DCH-0386 (Program Budget Cost Detail Schedule). Budget forms should reflect the proposed cost of the project period. Attach the forms to the application.

J. Overall Quality of the Proposal-- Include the requested information.

II. Narrative Guidelines

A. Font: Please use an easily readable serif typeface, such as Times Roman, Courier, or CG Times. The text portion of the application must be submitted in not less than 12 point and 1.0 line spacing. For charts, graphs, footnotes and budget tables, applicants may use a different pitch or size font, not less than 10 pitch or size font. However, it is vital that when scanned and/or reproduced, the charts are still clear and readable.

B. Paper Size and Margins: The application must be printed on 8 ½" X 11" white paper. Margins must be at least one (1) inch at the top, bottom, left and right of the paper. Please left-align text.

C. Page Numbering: Please number all pages, beginning with the title page as page 1.

D. Page Limit: Page limit is 10 pages; the Title Page, Cover Sheet, Work Plan, Program Budget, and Letters of Support are not included in the page limit.

Primary and Preventive Dental Health Care Services Grant Application

Applications due: January 24, 2007

Cover Page:

A. Project Title:_____

B. Amount of Request: _____

- ☐ **Cannot exceed $67,206 for Grant 1 (Community-based dental clinic)**
- ☐ **Cannot exceed $46,007 for Grant 2 (Community dental health coordinator)**

C. Name of Applicant Organization: _____

Authorized Official: _____
Title: _____
Mailing Address: _____
City: _____ County: _____ ZIP: _____
Telephone: _____ Fax: _____
E-mail Address: _____

D. Contact Person: _____

Title: _____
Mailing Address: _____
City: _____ County: _____ ZIP: _____
Telephone: _____ Fax: _____
E-mail Address: _____

E. Legal Status of Organization *(check only one response)*

- ☐ Private, Non-Profit Entity (attach copy of IRS's 501 (C) (3) or other legal documentation verifying status
- ☐ Public Agency/Unit of a governmental

F. Federal Tax ID Number: _____

G. Authorizing Entity: I hereby affirm my authority and responsibility for the use of all equipment and/or educational training described in this application.

_____
Authorized Individual *(signature)*

_____ _____
Printed Name Date

II. Selection Criteria: Applications for grants will be reviewed by a committee established by the MDCH. The proposals will be evaluated in terms of clarity, detail, overall understanding of the concepts addressed, and understanding of the Department's objectives for increasing the number of beneficiaries receiving oral health services. Applications will be scored on the following criteria:

A. Needs Statement (20 points)– The needs statement is a concise, descriptive statement identifying the need(s) to be addressed by the project. Applicants will want to provide information of their status as a dental health professional shortage area and define the specific needs of the target population. The target population should include. populations bearing a disproportionate share of disease and disabilities. Specifically, the application should explain why the request is being made; what need the request will impact; and why the need is not being met with current resources. Need for the project should be supported by local and/or state data.

B. Program Description/Workplan (15 points)- Applicants must complete the *Workplan* worksheet that follows, stating the project's goals, objectives, activities, and outcomes. The project goal(s) should be a broad statement of purpose. Project objectives should be time-limited and measurable. Project activities should indicate who will carry them out, as well as the timeframe in which they will occur. Program description should identify how the target population will be informed of services available, describe what services will be performed, describe community engagement activities and detail how the project will be evaluated.

C. Community Involvement, Collaboration, Coordination (10 points) – Proposals that demonstrate a collaborative community effort through significant involvement of agencies such as local health departments, local DHS offices, schools, community health centers and other agencies will receive higher scores. Coordination among involved agencies will also be evaluated. Letters to support collaboration efforts must be attached.

D. Innovative Methods: Describe the innovative nature of the project. Describe the target population and how the proposal specifically addresses (20 points)

Grant 1: Increasing dental access through a community-based clinic
Grant 2: Oral health prevention activities of the community dental health coordinator

E. Organization and Capacity (10 points)-- The organization should demonstrate collaboration for comprehensive health care partnerships or experience in partnering with communities. Special consideration will be given to applicants that are located within a community-based clinic that offers a full range of healthcare services to populations bearing a disproportionate share of disease and disabilities. Experience in the provision of oral health services to Medicaid recipients should be stated.

F. Project Sustainability (15 points)-- The proposal must demonstrate the capacity to sustain services beyond the nine-month term of the contract.

G. Outcome Measures and Evaluation (15 points): List the project's outcomes on *the Workplan* worksheet that follows. Describe what major outcomes are expected as a result of the project. How will outcomes be monitored and reported? How will the data be collected and how often? Outcomes should quantify the proposed expected change that the project intends to accomplish. For example:
Grant 1: *Documentation of dental services placed, number of clients served, number of patients with disabilities served, etc.*
Grant 2*: Documentation of baseline mean pit and fissure caries severity in targeted permanent molars among children three years older than target population; the number of sealants placed on molars; retention of sealants; participation of the target population; efficiency and effectiveness of the project; and cost-analysis of the program*

H. Budget Narrative and Summary (15 points) -- **Identify the amount of funds requested and any cost sharing** among partners. Be sure to include all revenues necessary to support the proposed projects. (Descriptions should correspond with information submitted on the DCH 0385 form). **Identify the project's fiduciary. Complete and attach the DCH 0385 and DCH 0386.** Funds available under this announcement for both Grant 1 and Grant 2 should be primarily focused on staff salaries. Funds may be used for materials, supplies and travel associated with implementing the proposed project but should not be the main focus of the proposal. Funds may not be used to supplant funds for existing projects. Funds for Grant 2 (community dental health coordinator) may be used for equipment such as a portable dental unit. Matching funds: Matching non-Federal funds of 40% are required. In-kind support: In-kind contributions of staff time and other resources are expected both from the applicant and project partners.

I. Overall Quality of the Proposal (10 points)-- Proposals must demonstrate effective, efficient and ongoing community-based approaches leading to an increase in primary and preventive dental heath care services.

WORK PLAN – State the overall goal of the project, and list objectives, activities, outcomes and the quarter in which the objectives are expected to be completed in the appropriate column.

Project Goal: _____

_____

Objectives	Performance Measure	Time Frame	Person Responsible

ATTACHMENT A – Budget Completion Instructions

INSTRUCTIONS FOR PREPARTION OF BUDGET FORMS (DCH-0385, DCH-0386)
MICHIGAN DEPARTMETN OF COMMUNITY HEALTH
PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION (continued)

I. INTRODUCTION

The budget should reflect all expenditures and funding sources associated with the program, including fees and collections and local, state and federal funding sources. When developing a budget it is important to note that total expenditures for a program must equal total funds.

The Program Budget Summary (DCH-0385) is utilized to provide a standard format for the presentation of the financial requirements (both expenditure and funding) for each applicable program. Detail information supporting the Program Budget Summary is contained in the Program Budget-Cost Detail Schedule (DCH-0386). General instruction for the completion of these forms follows in Sections II-III. Budgets must be submitted on Michigan Department of Community Health approved forms.

II. PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION

Use the **Program Budget Summary (DCH-0385)** supplied by the Michigan Department of Community Health. An example of this form is attached **(see Attachment B.1)** for reference. **The DCH-0386 form should be completed prior to completing the DCH-0385 form.** (Please note: the excel workbook version of the DCH 0385-0386 automatically updates the Program Summary amounts as the user completes the DCH-0386).

A. Program - Enter the title of the program.

B. Date Prepared - Enter the date prepared.

C. Page _____ of ____ - Enter the page number of this page and the total number of pages comprising the complete budget package.

D. Contractor Name - Enter the name of the Contractor.

E. Budget Period - Enter the inclusive dates of the budget period.

F. Mailing Address - Enter the complete address of the Contractor.

G. Budget Agreement: Original or Amended - Check whether this is an original budget or an amended budget. The budget attached to the agreement at the time it is signed is considered the original budget although it may have been revised in the negotiation process. If the budget pertains to an amendment, enter the amendment number to which the budget is attached.

H. Federal Identification Number – Enter the Employer Identification Number (EIN), also known as a Federal Tax Identification Number.

I. Expenditure Category Column – All expenditure amounts for the DCH-0385 form should be obtained from the total amounts computed on the Program Budget - Cost Detail Schedule (DCH-0386). (See Section III for explanation of expenditure categories.)

Expenditures:

1. Salaries and Wages
2. Fringe Benefits
3. Travel
4. Supplies and Materials
5. Contractual (Subcontracts/Subrecipients)
6. Equipment
7. Other Expenses
8. Total Direct Expenditures
9. Indirect Cost
10. Total Expenditures

J. Source of Funds – Refers to the various funding sources that are used to support the program. Funds used to support the program should be recorded in this section according to the following categories:

11. Fees and Collections - Enter the total fees and collections estimated. The total fees and collections represent funds that the program earns through its operation and retains for operation purposes. This includes fees for services, payments by third parties (insurance, patient collections, Medicaid, etc.) and any other collections.

12. State Agreement - Enter the amount of MDCH funding allocated for support of this program. This amount includes all state and federal funds received by the Department that are to be awarded to the Contractor through the agreement.

13. Local - Enter the amount of Contractor funds utilized for support of this program. In-kind and donated services from other agencies/sources should not be included on this line.

14. Federal - Enter the amount of any Federal grants received directly by the Contractor in support of this program and identify the type of grant received in the space provided.

15. Other(s) - Enter and identify the amount of any other funding received. Other funding could consist of foundation grants, United Way grants, private donations, fund-raising, charitable contributions, etc. In-kind and donated services should not be included unless specifically requested by MDCH.

16. Total Funding - The total funding amount is entered on line 16. This amount is determined by adding lines 11 through 15. The total funding amount must be equal to line 10 - Total Expenditures.

K. Total Budget Column - The Program Budget Summary is designed for use in presenting a budget for a specific program agreement funded in part by or through the Department or some other non-local funding source. Total Budget column represents the program budget amount. **The "K" Total Budget column must be completed while the remaining columns are not required unless additional detail is required by the Department.**

III. PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM PREPARATION

Use the **Program Budget-Cost Detail Schedule (DCH-0386)** supplied by the Michigan Department of Community Health. An example of this form is attached **(see Attachment B.2)** for reference. Use additional pages if needed.

A. Page ____ of ____ - Enter the page number of this page and the total number of pages comprising the complete budget package.

B. Program - Enter the title of the program.

C. Budget Period - Enter the inclusive dates of the budget period.

D. Date Prepared - Enter the date prepared.

E. Contractor Name - Enter the name of the contractor.

F. Budget Agreement: Original or Amended - Check whether this is an original budget or an amended budget. If an amended budget, enter the amendment number to which the budget is attached.

Expenditure Categories:

G. Salaries and Wages - Position Description - List all position titles or job descriptions required to staff the program. This category includes compensation paid to all permanent and part-time employees on the payroll of the contractor and assigned directly to the program. This category does not include contractual services, professional fees or personnel hired on a private contract basis. Consulting services, professional fees or personnel hired on a private contracting basis should be included in Other Expenses. Contracts with subrecipient organizations such as cooperating service delivery institutions or delegate agencies should be included in Contractual (Subcontracts/Subrecipients) Expenses.

H. Positions Required - Enter the number of positions required for the program corresponding to the specific position title or description. This entry could be expressed as a decimal (e.g., Full-time equivalent – FTE) when necessary. If other than a full-time position is budgeted, it is necessary to have a basis in terms of a time study or time reports to support time charged to the program.

I. Total Salary - Compute and enter the total salary cost by multiplying the number of positions required by the annual salary.

J. Comments - Enter any explanatory information that is necessary for the position description. Include an explanation of the computation of Total Salary in those instances when the computation is not straightforward (i.e., if the employee is limited term and/or does not receive fringe benefits).

MICHIGAN DEPARTMETN OF COMMUNITY HEALTH
PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION (continued)

K. Salaries and Wages Total - Enter a total in the Position Required column and the Total Salaries and Wages column. The total salary and wages amount is transferred to the Program Budget Summary - Salaries and Wages expenditure category. If more than one page is required, a subtotal should be entered on the last line of each page. On the last page, enter the total Salaries and Wages amounts.

L. Fringe Benefits – Check applicable fringe benefits for staff working in this program. This category includes the employer=s contributions for insurance, retirement, FICA, and other similar benefits for all permanent and part-time employees. Enter composite fringe benefit rate and total amount of fringe benefit. (The composite rate is calculated by dividing the fringe benefit amount by the salaries and wage amount.)

M. Travel - Enter cost of employee travel (mileage, lodging, registration fees). **Use only for travel costs of permanent and part-time employees assigned to the program**. This includes cost for mileage, per diem, lodging, lease vehicles, registration fees and approved seminars or conferences and other approved travel costs incurred by the employees (as listed under the Salaries and Wages category) for conducting the program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Travel category (line 3) exceeds 10% of the Total Expenditures (line 10).** Travel of consultants is reported under Other Expenses - Consultant Services.

N. Supplies & Materials - Enter cost of supplies & materials. This category is used for all consumable and short-term items and equipment items costing less than five thousand dollars ($5,000). This includes office supplies, computers, office furniture, printers, printing, janitorial, postage, educational supplies, medical supplies, contraceptives and vaccines, tape and gauze, education films, etc., according to the requirements of each applicable program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Supplies and Materials category (line 4) exceeds 10% of the Total Expenditures (line 10).**

O. Contractual (Subcontracts/Subrecipients) – **Specify the subcontractor(s) working on this program in the space provided under line 5.** Specific details **must** include: 1) subcontractor(s) and/or subrecipient(s) name and address, 2) amount by subcontractor and/or subrecipient, 3) the total amount for all subcontractor(s) and/or subrecipient(s). Multiple small subcontracts can be grouped (e.g., various worksite subcontracts). Use this category for written contracts or agreements with subrecipient organizations such as affiliates, cooperating institutions or delegate

the subrecipient contractor. Vendor payments such as stipends and allowances for trainees, fee-for-service or fixed-unit rate patient care, consulting fees, etc., are to be identified in the Other Expense category.

P. Equipment - Enter a description of the equipment being purchased (including number of units and the unit value), the total by type of equipment and total of all equipment. This category includes stationary and movable equipment to be used in carrying out the objectives of the program. The cost of a single unit or piece of equipment includes the necessary accessories, installation costs and any taxes. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. **Equipment items costing less than five thousand dollars ($5,000) each are to be included in the Supplies and Materials category. All equipment items summarized on this line must include: item description, quantity and budgeted amount and should be individually identified in the space provided under line 6. Upon completing equipment purchase, equipment must be tagged and listed on the Equipment Inventory Schedule (see Attachment B.3) and submitted to the agreement's contract manager.**

Q. Other Expenses - This category includes other allowable cost incurred for the benefit of the program. The most significant items should be specifically listed on the Cost Detail Schedule. Other minor items may be identified by general type of cost and summarized as a single line on the Cost Detail Schedule to arrive at a total Other Expenses category. Some of the more significant groups or subcategories of costs are described as follows and should be individually identified in the space provided on and under line 7. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Other Expenses category (line 7) exceeds 10% of the Total Expenditures (line 10).**

1. Communication Costs - Costs of telephone, telegraph, data lines, Internet access, websites, fax, email, etc., when related directly to the operation of the program.

2. Space Costs - Costs of building space, rental and maintenance of equipment, instruments, etc., necessary for the operation of the program. If space is publicly owned, the cost may not exceed the rental of comparable space in privately owned facilities in the same general locality. Department funds may not be used to purchase a building or land.

3. Consultant or Vendor Services - These are costs for consultation services, professional fees and personnel hired on a private contracting basis related to the planning and operations of the program, or for some special aspect of the project. Travel and other costs of these consultants are also to be included in this category.

4. Other - All other items purchased exclusively for the operation of the program and not previously included, patient care, fee for service, auto and building insurance, automobile and building maintenance, membership dues, fees, etc.

R. Total Direct Expenditures – Enter the sum of items 1 – 7 on line 8.

S. Indirect Cost Calculations - **Enter the allowable indirect costs for the budget.** Indirect costs can only be applied if an approved indirect cost rate has been established or an actual rate has been approved by a State of Michigan department (i.e., Michigan Department of Education) or the applicable federal cognizant agency and is accepted by the Department. Attach a current copy of the letter stating the applicable indirect cost rate. **Detail on how the indirect cost was calculated must be shown on the Cost Detail Schedule (DCH-0386)**.

T. Total Expenditures – Enter the sum of items 8 and 9 on line 10.

PROGRAM BUDGET SUMMARY

View at 100% or Larger MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Use WHOLE DOLLARS Only

PROGRAM (A) Budget and Contracts			**DATE PREPARED** (B) **7/01/xx**		**Page** (C) **1**	**Of** **2**
CONTRACTOR NAME (D) Michigan Agency			**BUDGET PERIOD** (E) **From:** 10/01/xx **To:** 9/30/xx			
MAILING ADDRESS (Number and Street) (F) 123 ABC Drive			(G) **BUDGET AGREEMENT** ☐ **ORIGINAL** ☒ **AMENDMENT** ▶		**AMENDMENT #** **1**	
CITY Acme	**STATE** MI	**ZIP CODE** 44444	**FEDERAL ID NUMBER** (H) 38-1234567			

(I) **EXPENDITURE CATEGORY**				(K) **TOTAL BUDGET** (Use Whole Dollars)
1. SALARIES & WAGES	**43,000**			**43,000**
2. FRINGE BENEFITS	**11,180**			**11,180**
3. TRAVEL	**1,400**			**1,400**
4. SUPPLIES & MATERIALS	**37,000**			**37,000**
5. CONTRACTUAL (Subcontracts/Subrecipients)	**3,500**			**3,500**
6. EQUIPMENT	**5,000**			**5,000**
7. OTHER EXPENSES				
	8,000			**8,000**
8. **TOTAL DIRECT EXPENDITURES** (Sum of Lines 1-7)	**109,080**			**109,080**
9. INDIRECT COSTS: Rate #1 %				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES	**109,080**			**109,080**

EXAMPLE

(J) **SOURCE OF FUNDS**

11. FEES & COLLECTIONS	**10,000**			**10,000**
12. STATE AGREEMENT	**90,000**			**90,000**
13. LOCAL	**9,080**			**9,080**
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING	**109,080**			**109,080**

AUTHORITY: P.A. 368 of 1978 **COMPLETION:** Is Voluntary, but is required as a condition of funding	The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0385 (E) (Rev 5-06) (W) Previous Edition Obsolete.

PROGRAM BUDGET – COST DETAIL SCHEDULE

(A) Page 2 Of 2

View at 100% or Larger
Use WHOLE DOLLARS ONLY

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

(B) PROGRAM	(C) BUDGET PERIOD		DATE PREPARED
Budget and Contracts	From: 10/01/xx	To: 9/30/xx	7/01/xx
(E) CONTRACTOR NAME Michigan Agency	(F) BUDGET AGREEMENT ☒ORIGINAL ☐AMENDMENT		AMENDMENT #

(G) 1. SALARY & WAGES POSITION DESCRIPTION	(H) COMMENTS	(I) POSITIONS REQUIRED	(J) TOTAL SALARY
Nurse	9 month position	1	25,000
Project Director		.5	18,000
	(K) 1. TOTAL SALARIES & WAGES:	1.5	$ 43,000

(L) 2. FRINGE BENEFITS (Specify)

☒FICA ☐LIFE INS. ☐DENTAL INS COMPOSITE RATE AMOUNT 26%
☒UNEMPLOY INS. ☐VISION INS. ☒WORK COMP
☐RETIREMENT ☐HEARING INS.
☐HOSPITAL INS. ☐OTHER (specify) _____

2. TOTAL FRINGE BENEFITS: $ 11,180

(M) 3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)

Conference registration $350
Airfare $600
Hotel accommodations and per diem for 4 days $450

3. TOTAL TRAVEL: $ 1,400

(N) 4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures)

Office Supplies 2,000
Medical supplies 35,000

4. TOTAL SUPPLIES & MATERIALS: $ 37,000

EXAMPLE

(O) 5. CONTRACTUAL (Specify Subcontracts/Subrecipients)

Subcontractor Name	Address	Amount
ACME Evaluation Services	555 Walnut, Lansing, MI 48933	$ 2,000
Subrecipient Name		
Health Care Partners	333 Kalamazoo, Lansing, MI 48933	$ 1,500

5. TOTAL CONTRACTUAL: $ 3,500

(P) 6. EQUIPMENT (Specify items)

Microscope $5,000

6. TOTAL EQUIPMENT: $ 5,000

(Q) 7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures)

Communication Costs $2,400
Space Costs $3,600
Consultant or Vendor: John Doe, Evaluator, 100 Main, E. Lansing $2,000

7. TOTAL OTHER: $ 8,000

(R) 8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7) 8. TOTAL DIRECT EXPENDITURES: $ 109,080

9. INDIRECT COST CALCULATIONS

Rate #1: Base $0 X Rate 0.0000 % Total $ 0
Rate #2: Base $0 X Rate 0.0000 % Total $ 0

9. TOTAL INDIRECT EXPENDITURES: $ 0

(T) 10. TOTAL EXPENDITURES (Sum of lines 8-9) $ **109,080**

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0385 (E) (Rev 5-06) (W) Previous Edition Obsolete. Use Additional Sheets as Needed

ATTACHMENT B.1

PROGRAM BUDGET SUMMARY

View at 100% or Larger **MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**

Use WHOLE DOLLARS Only

PROGRAM			**DATE PREPARED**	**Page**	**Of**
CONTRACTOR NAME			**BUDGET PERIOD** From To:		
MAILING ADDRESS (Number and Street)			**BUDGET AGREEMENT** ☐ ORIGINAL ☐ AMENDMENT ▶	**AMENDMENT #**	
CITY	**STATE**	**ZIP CODE**	**FEDERAL ID NUMBER**		

EXPENDITURE CATEGORY				**TOTAL BUDGET** (Use Whole Dollars)
1. SALARIES & WAGES				
2. FRINGE BENEFITS				
3. TRAVEL				
4. SUPPLIES & MATERIALS				
5. CONTRACTUAL (Subcontracts/Subrecipients)				
6. EQUIPMENT				
7. OTHER EXPENSES				
9. **TOTAL DIRECT EXPENDITURES** (Sum of Lines 1-7)	$0	$0	$0	$0
9. INDIRECT COSTS: Rate #1 %				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES	**$0**	**$0**	**$0**	**$0**

SOURCE OF FUNDS

11. FEES & COLLECTIONS				
12. STATE AGREEMENT				
13. LOCAL				
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING	**$0**	**$0**	**$0**	**$0**

AUTHORITY: P.A. 368 of 1978 **COMPLETION:** Is Voluntary, but is required as a condition of funding	The Department of Community Health is an equal opportunity employer, services and programs provider.

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ATTACHMENT B.2

PROGRAM BUDGET – COST DETAIL SCHEDULE

View at 100% or Larger
Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Page of

PROGRAM	BUDGET PERIOD From:	BUDGET PERIOD To:	DATE PREPARED
CONTRACTOR NAME	BUDGET AGREEMENT ☐**ORIGINAL** ☐**AMENDMENT**		**AMENDMENT #**

1. SALARY & WAGES POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY
			$0
			$0
			$0
			$0
	1. TOTAL SALARIES & WAGES:	0	$ 0

2. FRINGE BENEFITS (Specify) ☐ FICA ☐LIFE INS. ☐DENTAL INS. COMPOSITE RATE ☐UNEMPLOY INS. ☐VISION INS ☐WORK COMP. AMOUNT 0.00% ☐RETIREMENT ☐HEARING INS. ☐HOSPITAL INS. ☐OTHER (specify) _____ **2. TOTAL FRINGE BENEFITS:**	$0
3. TRAVEL (Specify if category exceeds 10% of Total Expenditures) **3. TOTAL TRAVEL:**	$0
4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures) **4. TOTAL SUPPLIES & MATERIALS:**	$0
5. CONTRACTUAL (Specify Subcontracts/Subrecipients) Name Address Amount **5. TOTAL CONTRACTUAL:**	$0
6. EQUIPMENT (Specify items) **6. TOTAL EQUIPMENT:**	$0
7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures) **7. TOTAL OTHER:**	$0
8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7) 9. **8. TOTAL DIRECT EXPENDITURES:**	$**!D13 Is Not In Table**
9. INDIRECT COST CALCULATIONS **Rate #1: Base $0 X Rate 0.0000 % Total** **Rate #2: Base $0 X Rate 0.0000 % Total** **9. TOTAL INDIRECT EXPENDITURES:**	$ 0 $ 0 $ 0
10. TOTAL EXPENDITURES (Sum of lines 8-9)	$ 0

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

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